b. SPAD Add-On for Emergency Department Services

Effective October 19, 1996, an additional amount was added to every hospital's per discharge payment rate to account for routine Emergency Department services that result in an inpatient admission. This amount was calculated as follows. The average Medicaid rate of payment for emergency visits for all hospitals in RY95 was multiplied by the percentage of inpatient admissions for all hospitals in RY95 that were admitted through the Emergency Department. This rate was then multiplied by an inflation factor of 3.16% to reflect price changes between RY95 and RY96, and by an inflation factor of 2.38% to reflect price changes between RY96 and RY97. The amount of add-on for RY97 is $26.40.

c. SPAD Add-On for Observation Services

Effective October 19, 1996, an additional amount was added to every hospital's per discharge payment rate to account for routine observation services which result in an inpatient admission. This amount was calculated as follows. The average Medicaid rate of payment for observation services for all hospitals in RY95 was multiplied by the percentage of inpatient admissions for all hospitals in RY95 that were admitted from an observation bed. This rate was then multiplied by an inflation factor of 3.16% to reflect price changes between RY95 and RY96, and by an inflation factor of 2.38% to reflect price changes between RY96 and RY97. The amount of this add-on for RY97 is $11.62.

3. Calculation of the Pass-through Amount per Discharge

The inpatient portion of malpractice costs was derived from each hospital's FY95 RSC 403 report as screened and updated as of June 20, 1996. The pass-through amount per discharge is the sum of the per discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the hospital's inpatient portion of expenses by the number of total, all-payer days and then multiplying the cost per diem by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division used the Medicaid audited paid claims file for date of payment for the period June 1, 1995 through May 31, 1996 to develop RY97 casemix data.

The RY98 inpatient portion of malpractice and organ acquisition costs will be calculated as described above, except that the data source will be the FY96 RSC-403 report as screened and updated as of June 20, 1997.

4. Direct Medical Education

The inpatient portion of direct medical education costs was derived from each hospital's FY95 RSC-403 report. For hospitals which began new primary care physician training programs between October 1, 1994 and July 1, 1995, effective October 19, 1996, the Division shall recognize, through September 30, 1997, such new costs submitted by the hospital, as are determined to be reasonable by the Division, to be revised using costs which shall be based on costs reported in the FY96 RSC 403 Report as filed. Such incremental costs for new programs shall be annualized. In each instance, the amount was calculated by dividing the hospital's inpatient portion of expenses by the number of total inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division used the Medicaid paid claims file for dates of payment for the period June 1, 1995 through May 31, 1996 to develop the RY97 casemix index. The Division has incorporated an incentive in favor of primary care training which was factored into the recognized direct medical education costs by weighting costs in favor of primary care training. An incentive of 33% of the costs was added to the per discharge cost of primary care training; a reduction of 20% of the costs was subtracted from the per discharge cost of specialty care training. The number of primary care and specialty care trainees was derived from data provided to the Division by the hospitals.

Growth in direct medical education costs attributable to wage inflation will be subjected to a 5% annual limit. An audit may be performed by the Division to verify the appropriateness of reported teaching costs.

The RY98 inpatient portion of direct medical education costs will be calculated as described above, except that the data source will be the FY96 RSC-403 report, as screened and updated as of June 20, 1996.

5. Capital Payment Amount per Discharge

The capital payment per discharge in the RY97/RY98 RFA reflects the fifth and final year of the phase-in of a standard, prospective capital reimbursement for all hospitals. The capital payment is a casemix-adjusted capital cost limit, based on the FY91 Medicare Cost Report (2552), updated for inflation.

For each hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, and long-term and short-term interest. Total capital costs are allocated to inpatient services through the square footage-based allocation formula used in the Medicare cost report

(2552). The Medicare cost report is also used to identify capital allocated to distinct part psychiatric units and to subtract this amount from total inpatient capital in order to calculate the non-DPU capital cost per discharge.

The capital cost per discharge is calculated by dividing total inpatient capital costs (less that allocated to psychiatric DPU) by the hospital's total non-DPU days, and then multiplying by the hospital-specific non-DPU Medicaid average length of stay from casemix data.

The casemix-adjusted capital efficiency standard is determined by a) dividing each hospital's FY91 capital cost per discharge by its FY91 casemix index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. The casemix-adjusted capital efficiency standard is established at the cost per discharge corresponding to the median discharge.

The capital efficiency standard was updated for inflation between RY93 and RY94 by a factor of 3.01%; for inflation between RY94 and RY95 by a factor of 2.80%; for inflation between RY95 and RY96 by a factor of 1.80%; and for inflation between RY96 and RY97 by a factor of 1.00%. The RY97 capital update factor is taken from annual HCFA regulations used by HCFA to update the capital payments made by Medicare. The capital update factor is computed annually by HCFA and is calculated as follows: HCFA estimates of inflation in depreciation, interest, and other capital related expenses, is multiplied by their respective weights, and summed. For RY97, the casemix-adjusted capital efficiency standard per discharge is $316.42.

The RY98 capital payment amount per discharge will be calculated as described above, except for the addition of an update factor to reflect price changes between RY97 and RY98.

6. **Maternity and Newborn Rates**

Maternity cases in which delivery occurs will continue to be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for all services (except physician services) provided in conjunction with such a maternity stay including, but not limited to, follow-up home visits provided as incentives for short delivery stays, are included in the SPAD amount. There will be no additional payments to the hospital or other entities (i.e. VNA's, home health agencies) for providing these services in collaboration with the hospital. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payor.

7. **Payment for Psychiatric Services in Distinct Part Psychiatric Units**

Services provided to non-managed care Medicaid patients in distinct part psychiatric units shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which services are provided to Medicaid recipients assigned to MH/SAP.

The regions used to develop the all-inclusive regional weighted average per diem rates correspond to the six Health Services Areas established by the Massachusetts Department of Public Health (PL 93-641). These regional weighted average per diems were calculated by a) dividing each hospital's per discharge psychiatric rate established in the FY92 Medicaid RFA by the FY90 average length of stay pertaining to Medicaid psychiatric patients; b) multiplying the result for each hospital by the ratio of the hospital's Medicaid mental health days to the total Medicaid mental health days for the hospital's region; and c) summing the results for each region. The regional weighted average per diems were updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; 3.16% to reflect price changes between RY95 and RY96; and 2.38% to reflect price changes between RY96 and RY97. An adjustment will be made, derived from the same source as the previous year, to reflect price changes between RY97 and RY98.

For hospitals which are part of the Division's MCO network, the lower of the MCO's negotiated rate or the psychiatric per diem shall be the rate of payment in all cases where the psychiatric per diem established in the RFA applies.

8. **Outlier Payments**

Eligibility

A hospital qualifies for an outlier per diem payment in addition to the standard payment amount if **all** *of the following conditions are* met:

- *the length of stay for the hospitalization exceeds twenty (20) cumulative* **acute** *days (not including days in a distinct part psychiatric unit);*
- *the hospital continues to fulfill its discharge planning duties;*
- *the patient continues to need acute level care and is therefore* **not** *on administrative day status on any day for which an outlier payment is claimed;*

- the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed; and
- the patient is not a patient in a chronic unit (as described in Section IV.B.13) for which a chronic per diem has been established.

To derive the standard payment amount per day, the statewide average payment amount per discharge of $2,622.08 is divided by the average FY95 all-payer length of stay of 5.0931 days which equals $514.83. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid average length of stay.

The outlier per diem payment amount is equal to fifty-five percent (55%) of the statewide average payment amount per day multiplied by the hospital's wage area index and casemix index, plus a per diem payment for the hospital's pass-through costs, direct medical education and capital payment amounts.

The RY98 outlier per diem will be calculated as described above, updated using the RY98 standard payment amount per discharge, capital, direct medical education, and pass-through payments.

9. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one acute hospital to another will be made on a transfer per diem basis (capped at the per discharge payment) for the hospital that is transferring the patient. The amount of the transfer per diem payment is equal to the RY 97 statewide average payment amount per day, multiplied by the transferring hospital's RY97 Medicaid casemix index and wage area index, plus pass-through, direct medical education and capital per diem payments.

To derive the standard payment amount per day for transfer patients, the RY97 statewide average payment amount per discharge of $2,622.08 is divided by the FY95 average all-payer Medicaid length of stay of 5.0931 days which equals $514.83. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay from casemix data.

The RY98 standard payment amount per day for transfer patients will be calculated as described above, updated using the RY98 standard payment amount per discharge, capital, direct medical education, and pass-through payments.

In general, the hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in Sections IV.B.2, IV.B.3, IV.B.4 and IV.B.5, if the patient is actually discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital will be paid at the hospital-specific transfer per diem rate, capped at the hospital-specific per discharge amount. Additionally, "back transferring" hospitals will be eligible for outlier payments specified in Section IV.B.8.

Refer to matrices attached as **Exhibit 3** for a review of transfer scenarios and corresponding payment mechanisms involving MH/SAP-eligible and MH/SAP-ineligible recipients in MH/SAP MCO's network and non-network hospitals.

b. **Transfers within a Hospital**

In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be reimbursed on a per diem basis. This section shall outline reimbursement under some specific transfer circumstances. For a complete review of reimbursement under transferring circumstances involving MH/SAP-eligible recipients and MH/SAP-ineligible recipients in the MH/SAP MCO network and non-network hospitals, refer to the matrices attached as **Exhibit 3**.

(1) Transfer to\from a Chronic Unit within the Same Hospital

If a patient is transferred from an acute bed to the chronic unit in the same hospital, the transfer is considered a discharge. The Division will pay the hospital-specific SPAD for the portion of the stay before the patient is transferred to a chronic unit. In addition, the hospital will bill its hospital-specific chronic per diem for each chronic level of care (as defined in 130 CMR 435.409 attached as **Exhibit 4**) day that the patient is in the Chronic Unit.

(2) **Medicaid Payments for Newly Eligible Recipients or in the Event of Exhaustion of Other Insurance**

When a patient becomes Medicaid-eligible or other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay will be paid at the transfer per diem rate, up to the hospital-specific SPAD, or, if the patient is at the administrative day level of care, at the AD per diem rate.

(3) **Admissions Involving One-Day Length of Stay Following Surgical Services**

If a patient who requires hospital inpatient services, is admitted for a one-day stay following outpatient surgery, the hospital shall be paid at the transfer per diem rate instead of the hospital-specific SPAD.

(4) **Transfer between a Distinct Part Psychiatric Unit and Any Other Bed within the Same Hospital**

Reimbursement for a transfer between a distinct part psychiatric unit and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, MH/SAP network or non-network hospital, or the type of service provided. Please refer to the appropriate matrix in **Exhibit 3** for reimbursement under specific transfer circumstances involving psychiatric stays.

(5) **Change of Managed Care Status during a Psychiatric or Substance Abuse Hospitalization**

(a) **Payments to hospitals <u>without</u> network provider agreements with the Division's MH/SAP MCO**

When a recipient becomes assigned to the MH/SAP during a non-emergency or emergency mental health or substance abuse admission at a non-network hospital, the portion of the hospital stay during which the recipient was assigned to the MH/SAP shall be paid by the Division's MH/SAP MCO. The portion of the hospital stay during which the recipient was not assigned to the MH/SAP will be paid by the Division at the psychiatric per diem rate for psychiatric services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

(b) **Payments to hospitals <u>with</u> network provider agreements with the Division's MH/SA Provider.**

When a patient becomes assigned to the MH/SAP during an emergency or non-emergency psychiatric or substance abuse hospital stay, the portion of the hospital stay during which the recipient was assigned to the MH/SAP shall be paid by the Division's MCO at the per diem rates agreed upon by the hospital and the MCO.

The portion of the hospital stay during which the recipient was not assigned to MH/SAP will be paid by the Division at the psychiatric per diem for mental health services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

10. **Physician Payment**

For physician services provided by hospital-based physicians to Medicaid inpatients, the hospital will be reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 et seq. (attached as Exhibit 5). Such reimbursement shall be at the lower of the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00 (Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)[1], or the hospital's usual and customary charge.

Hospitals will be reimbursed for such physician services only if the hospital-based physician took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the DME portion of the SPAD payment and, as such, are not reimbursable separately.

Hospitals shall not be reimbursed for inpatient physician services provided by community-based physicians.

11. **Payments for Administrative Days**

Payments for administrative days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals.

- The AD rate is comprised of a base per diem payment and an ancillary add-on.
- The base per diem payment is the average Medicaid nursing home rate in state fiscal year 1995 for acuity categories H to L. This base rate is $75.83. The ancillary add-on ratios of 0.0665 and 0.2969, for Medicare/Medicaid Part B eligible patients and Medicaid-

[1] These regulations are voluminous, and will be provided upon request.

only patients, respectively, were maintained for the RY97 RFA. The resulting AD rates (base and ancillary) were then updated for inflation using the update factors 3.16% for RY96 and 2.38% for RY97. The resulting AD rates for RY97 are $80.87 for Medicare/Medicaid Part B eligible patients and $130.43 for Medicaid-only eligible recipients.

- The RY98 administrative day per diem will be calculated as described above, updated to reflect price changes in RY98.

A hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD where the patient fluctuates between acute status and AD status; the hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for outlier days, as described above.

12. Chronic Per Diem

If in the FY90 base year, a hospital had a designated Chronic Unit of twenty-five (25) beds or more within the hospital, a chronic per diem was calculated. When a patient is admitted directly to a chronic unit, a hospital must bill the hospital-specific chronic per diem. There will be no outlier payments for patients in chronic units. This rate is based on the hospital's actual costs (as reported on the FY90 RSC-403) for chronic services delivered to Medicaid recipients. This rate shall be paid for every day that is considered chronic level of care according to the regulations as stated in the Chronic Disease and Rehabilitation Inpatient Hospital regulations at 130 CMR 435.409 et seq. (attached as Exhibit 4).

This per diem is all inclusive and represents payment in full for all chronic services. The derivation of the chronic per diem is as follows:

(a) A routine Cost-to-Charge Ratio (CCR) was calculated using routine chronic costs from the FY90 RSC-403, less major moveable equipment, divided by routine chronic charges from the FY90 RSC-403.

(b) The result was multiplied by the Medicaid chronic routine charges from the FY90 Medicaid claims data file to obtain routine Medicaid costs.

(c) The routine costs were added to the ancillary chronic Medicaid costs (which were also derived from the ancillary CCR, multiplied by FY90 Medicaid chronic ancillary charges) to obtain the total Medicaid chronic costs.

Effective October 1, 1996 through October 18, 1996:

(d) The total Medicaid chronic costs were divided by FY90 Medicaid chronic days (from the Medicaid claims data file) and added to the updated FY91 hospital-specific capital pass-through amount to arrive at the chronic per diem. The per diem was updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; 3.16% to reflect price changes between RY95 and RY96; and 2.38% to reflect price changes between RY96 and RY97.

Effective October 19, 1996:

(d) The total Medicaid chronic costs were divided by FY90 Medicaid chronic days (from the Medicaid claims data file) and added to the updated FY92 hospital-specific capital pass-through amount to arrive at the chronic per diem. The per diem was updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; 3.16% to reflect price changes between RY95 and RY96; and 2.38% to reflect price changes between RY96 and RY97.

For patients in a Chronic Unit on administrative day status, the rate is identical to the acute Administrative Day rate.

13. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to acute hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths-of-stay. Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.09(3)(d) (attached as Exhibit 6).

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to acute hospitals for inpatient hospital services furnished to children greater than one year of age and less than six years of age if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923(a) of the Social Security Act. (See Federally-Mandated Disproportionate Share Adjustment, Section IV.D.2 for qualifying hospitals.) Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.09(3)(c) (attached as Exhibit 6).

14. Emergency or Outpatient Department Visits which result in an Inpatient Admission

Services provided to a recipient in an acute hospital outpatient or emergency department on the same day as an inpatient admission of that patient to the same hospital are reimbursed through the inpatient payment methodology only.

C. Reimbursement for Unique Circumstances

1. Sole Community Hospital

The standard inpatient payment amount per discharge for a sole community hospital (as defined in Section II) shall be equal to the sum of:

95% of the hospital's FY95 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY97 pass-through amount per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of FY95 Medicaid costs is described in Section IV.B.2.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payor casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1995 through May 31, 1996.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, and 2.38% to reflect inflation between RY96 and RY97.

The RY98 standard inpatient payment amount per discharge for a sole community hospital will be calculated as described above, except for the addition of an update factor to reflect price changes between RY97 and RY98.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as sole community hospitals shall be determined by the Division.

2. Specialty Hospitals and Pediatric Units

The standard inpatient payment amount per discharge for specialty hospitals and hospitals with pediatric specialty units (as defined in Section II) shall be equal to the sum of:

95% of the hospital's FY95 cost per discharge, with the FY95 cost per discharge capped at 15% over the RY96 contract's FY90 base cost per discharge, adjusted for

casemix and inflation; and the hospital-specific RY97 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

The following paragraph is effective October 19, 1996.

For hospitals with pediatric specialty units, if the FY95 base cost per discharge constitutes more than a 10% reduction from the FY90 base cost per discharge adjusted for inflation, then in the calculation of the per discharge rate the inflation-adjusted FY90 based rate plus 5% shall be applied.

Derivation of FY95 Medicaid costs is described in Section IV.B.2.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payor casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1995 through May 31, 1996.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96 and 2.38% to reflect inflation between RY96 and RY97.

The RY98 standard inpatient payment amount per discharge for specialty hospitals and hospitals with pediatric specialty units will be calculated as described above, except for the addition of an update factor to reflect price changes between RY97 and RY98.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as specialty hospitals and pediatric units shall be determined by the Division.

3. Public Service Hospital Providers

The standard inpatient payment amount per discharge for public service hospital providers (as defined in Section II) shall be equal to the sum of:

95% of the hospital's FY95 cost per discharge, with the FY95 cost per discharge capped at 15% over the RY96

contract's FY90 base cost per discharge adjusted for casemix and inflation; and the hospital-specific RY97 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

The following paragraph is effective October 19, 1996.

For public service hospitals, if the FY95 base cost per discharge constitutes more than a 10% reduction from the FY90 base cost per discharge adjusted for inflation, then in the calculation of the per discharge rate the inflation-adjusted FY90 based rate plus 20% shall be applied.

Derivation of estimated actual FY90 Medicaid costs is described in Section IV.B.2.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payor casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1995 through May 31, 1996.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96 and 2.38% to reflect inflation between RY96 and RY97.

The RY98 standard inpatient payment amount per discharge for public service hospitals will be calculated as described above, except for the addition of an update factor to reflect price changes between RY97 and RY98.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. State-Owned Acute Teaching Hospitals

a. Subject to Section IV.C.4.b, the inpatient payment amount for state-owned acute teaching hospitals' acute non-psychiatric admissions shall be equal to the hospital's RY97 cost per discharges calculated as follows:

FY95 total hospital-specific inpatient non-psychiatric charges are multiplied by the hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using FY95 RSC 403, Schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and Schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the FY95 hospital-specific non-psychiatric Medicaid discharges to the FY95 total hospital non-psychiatric discharges to yield the Medicaid inpatient non-psychiatric cost. The Medicaid inpatient non-psychiatric cost is then divided by the number of FY95 Medicaid non-psychiatric discharges to calculate the Medicaid cost per discharge. This Medicaid cost per discharge is multiplied by the inflation rate of 3.16% to reflect inflation between RY95 and RY96, and 2.38% to reflect inflation between RY96 and RY97.

The RY98 standard inpatient payment amount per discharge for state owned acute teaching hospitals will be calculated as described above, except for the addition of an update factor to reflect price changes between RY97 and RY98.

b. Any payment amount in excess of amounts which would otherwise be due any state-owned teaching hospital pursuant to Sections IV.B.2-6 and 8-9 is subject to specific legislative appropriation.

D. Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments

Medicaid will assist hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment above the rate under the RFA contract for RY97 and RY98 to hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only hospitals that have an executed contract with the Division, pursuant to this RY97/RY98 RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. Medicaid-participating hospitals may qualify for adjustments and may receive them at any time throughout the rate year. If a hospital's RFA contract is terminated, its adjustment shall be prorated for the portion of RY97 or RY98 during which it had a contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible hospitals. The following describes how hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

In accordance with federal and state law, hospitals must have a Medicaid inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to regulations of the Division of Health Care Finance and Policy (DHCFP) found at 114.1 CMR 36.09(10) (attached as **Exhibit 7**). Also, the total amount of DSH payment adjustments awarded to any hospital shall not exceed the costs incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and by uninsured patients ("unreimbursed costs").

When a hospital applies to participate in Medicaid, its eligibility and the amount of its adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications. Therefore, some disproportionate share adjustments may require recalculation pursuant to DHCFP regulations set forth at 114.1 CMR 36.09(10) (attached as **Exhibit 7**). Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified

group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within Section IV.D, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2).

1. <u>High Public Payor Hospitals: Sixty-Three Percent Hospitals</u> (Total Annual Funding: $11,700,000)

   The eligibility criteria and payment formula for this DSH classification are specified in DHCFP regulations at 114.1 CMR 36.09(10)(a) (attached as Exhibit 7). For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payor mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payors and free care.

2. <u>Basic Federally-Mandated Disproportionate Share Adjustment</u> (Total Annual Funding: $200,000)

   The eligibility criteria and payment formula for this DSH classification are described in DHCFP regulations at 114.1 CMR 36.09(10)(b) (attached as Exhibit 7) and in accordance with the minimum requirements of 42 U.S.C. §1396r-4.

3. <u>Disproportionate Share Adjustment for Safety Net Providers</u>

   The eligibility criteria and payment formula for this DSH classification are specified in DHCFP regulations at 114.1 CMR 36.09(10)(c) attached as Exhibit 7) Payments will be made by the Division to eligible hospitals in accordance with their agreements with the Division concerning intergovernmental transfer of funds.

4. <u>Uncompensated Care Disproportionate Share Adjustment</u>

   Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in DHCFP regulations at 114.6 CMR 7.00 (attached as Exhibit 8). The payment amounts for eligible hospitals participating in the free care pool are determined and

paid by DHCFP in accordance with its regulations at 114.6 CMR 7.00.

5. **Medical Security Unemployment Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low-income unemployed individuals who are uninsured or covered only by a wholly state-financed program of medical assistance of the Department of Employment and Training (DET), in accordance with the regulations of DET set forth at 117 CMR 9.00 (attached as **Exhibit 9**). The payment amounts for eligible hospitals participating in the Medical Security Plan are determined and paid by the DET in accordance with its regulations at 117 CMR 9.00 and its ISA with the Division. The statutory authority is found at M.G.L. c.151A §14G (attached as **Exhibit 9**).

6. **Public Health Substance Abuse Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000 (attached as **Exhibit 10**), and DPH's ISA with the Division of Medical Assistance (Division). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 (attached as **Exhibit 10**) and DPH's ISA with the Division.

E. **Upper Limit Review and Federal Approval**

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA). If any portion of the reimbursement methodology is not approved by HCFA, the Division may recover any payment made to a hospital in excess of the approved methodology.